Chapter 5
APPROACHES TO CONSIDER

Introduction

In this chapter, the commission outlines a number of different approaches to stabilize overall health care costs and improve value within the health care delivery system. They are based on our analysis of the cost profile of Maine's health care expenditures, in addition to input received, and were selected from many ideas that we considered. They are *not* recommendations: indeed, some of them do not have the unanimous support of the commission members. They represent those approaches the commission found most worthy of further analysis.

The commission also asks readers to keep in mind several other considerations:

· The approaches have the potential to help stabilize costs over the long term, but some require an up-front investment;
· The approaches are described in concept, not in detail;
· Each approach requires much more analysis prior to implementation; and
· State government involvement in implementing the ideas will depend upon budgetary constraints, changing federal policy, and other compatible initiatives.

Policy Constraints

In the course of our work, we came across a number of factors that serve as barriers, or at least constraints, to potentially effective approaches. In many respects, those constraints served as boundaries within which we confined our approaches.

The State/Federal System: Health care delivery is influenced by a complex overlay of federal and state laws, tax policy, and spending policies. Many federal laws and budgetary policies constrain what Maine, or any state, can do. For instance, the federal Employee Retirement Income Security Act of 1974 (ERISA) governs all employee health plans established by private-sector employers, or by employee organizations such as unions. Furthermore, it supersedes many state health care initiatives such as employer insurance mandates and some types of managed care plan standards. In addition, Medicare spending, estimated to be about 20 percent of the total health care spending in Maine, is governed entirely by the federal Health Care Finance Administration. Finally, while Medicaid is largely a state-run program, it receives two-thirds of its funding from the federal government, and has strict and complex restraints on access to federal funds.

Employer-Based System: Employers began providing health care insurance to their employees as a result of wage caps imposed by the federal government during World War II. Today, employers are profoundly involved in providing health care insurance, and many workers have come to expect and rely on such benefits. Further, ERISA constrains state policy that might encourage movement away from the employer-based system.

Ambiguous Role of "Government:" Government's role in health care is not transparent. Unlike public education, for example, we are not deliberate about taxing citizens to provide funding for universal health care. Rather, we require the disadvantaged to be served through deeply entrenched, piecemeal government mandates, many of which promote cost

shifting and uneven distribution of the financial burden.

Cultural Norms and Values: As Americans, we expect exceptional health care delivered by the best doctors and best technology in the world. We are generally unwilling to accept less than that when a loved one is in need. That cultural expectation stifles our ability to consider rationing care.

Because of those and related constraints, the commission did not pursue certain options, notwithstanding their appeal.

For example, many testified that a universal health care program represented the ultimate solution to providing cost-effective, quality health care. Suggestions ranged from a "nationalized" single payer/provider system to a single payment program. Except for a modest adaptation of that concept (see Approach 10c), the commission concluded that a universal health care program was beyond the capacity of an individual state, requiring federal action.

Some advocated for comprehensive community rating, which requires insurance companies to apply similar rates to large groups of people, regardless of varying characteristics within the group. Although Maine currently has limited community rating, the commission concluded that expanding its scope might drive even more insurance companies from the state—and contribute to rising health insurance costs.

A related concept put forward is known as "pay or play," under which all Maine employers would be required to provide health insurance coverage for their employees, or to pay a tax that would allow the state to provide coverage. Federal preemption, concerns about further erosion in the private insurance market, and concern about negative impacts on economic development caused the commission to not pursue that approach.

The commission was very aware and sensitive to the impact of rising pharmaceutical costs on all Maine residents, particularly on the elderly and uninsured. Concurrent to the commission's deliberations, a great deal of legislative activity was focused on that issue. Thus we concluded that the state is paying adequate attention to the issue, and that there was probably little it could add.

Finally, there were a number of suggestions regarding purchasing alliances, the forming of large groups of people capable of negotiating volume discounts. There is evidence to suggest that such alliances have had only limited success in other states, and that the state could not form a large enough pool to make a substantial difference. In addition, a legislative committee and other groups are currently exploring the feasibility of alliances. None-the-less, we have introduced a modified version (see Approach 10b).

Policy Guidelines

The commission feels that to stabilize health care costs over the long run Maine's policymakers should agree on a common set of guidelines for future policy development. Doing so would ensure that policies are not in conflict with each other, and that all approaches are at least moving us in a common direction—toward cost stabilization. The commission urges that all health-care policies consider the following guidelines, which are presented in no particular order.

Promote Informed Choice

In the absence of a system of health care in which neither regulation or the free market is successfully stabilizing costs, we suggest a third way: informed choice. The notion rests on the premise that more complete information invariably results in better choices and better decisions by consumers, providers, and policymakers.

If consumers knew how much every procedure cost, the price of every prescription, every test, every therapy, it would affect the health care choices they made, even if it did not change their own out-of-pocket contributions. In other words, total transparency and full reporting of health care costs would have a significant cost-stabilizing effect over the long run.

If providers knew the cost of every procedure and

drug they prescribed, or how their treatments compared to those of other providers, or if they were more aware of risks and benefits of certain procedures, that knowledge might have an effect on the choices they make.

Further, full reporting of utilization rates, health outcomes, and health status by region and demographic factors would greatly assist policymakers in determining where to direct scarce resources.

Thus future policies should not further shield consumers and policymakers from knowing actual costs of specific procedures, but should move toward total transparency and full reporting.

Target Prevention

Poor health drives health care costs. To stabilize costs over the long run, we must invest in preventing poor health. Short-term investment in prevention will return better health and lower health care costs in the long term.

Prevention investment should be targeted towards those populations where it will have the largest effect on future health care costs: among children and poor adults. And public health efforts should be delivered at the community level.

Collaborate for Mutual Gain

The Maine health care market is too small, its services too costly, and health care itself too precious for us not to collaborate to provide the highest quality, most cost-effective services possible.

Collaboration for mutual gain might take the form of consolidating facilities and other aspects of service delivery; pooling groups of people to purchase insurance, health care services, and pharmaceuticals; consolidating the processing of claims and billing; sharing information; and collaborating with other states.

Future policies should move in the direction of increased collaboration, not toward proliferation of duplicative services. While collaboration may at times reduce access, as a state we need to ponder what level of access we can afford.

Encourage Personal Responsibility

Assuming greater individual responsibility for personal health would result in better understanding of the risk factors and health outcomes of certain behaviors. It would mean better understanding of treatment options, as well as and making health decisions in collaboration with medical care professionals. It would mean taking responsibility for personal medical records, and making them available to health care professionals when needed. It would also mean taking steps to provide financially for unforeseen tragedies.

Future policies should encourage people to take greater responsibility for their personal health and health care, and should not encourage unreasonable shifting of responsibilities.

Discourage Cost Shifting

Some cost shifting is legitimate and perfectly appropriate. At its best, it recognizes that although not everyone has the same ability to pay, no one should go without health care. Indeed, insurance itself is a form of cost shifting in which most of us voluntarily participate.

But health care cost shifting has evolved to a point of unreasonable complexity and unfairness. Despite its aim to provide basic health care to all, it lacks a deliberate, equitable means to cover its costs. As a consequence, some people pay far more for services than those services cost, while others pay less than actual costs. In other words, charges for services often have little relationship to the actual costs of providing them.

The system is complex, frustrating, and unfair. From a policy perspective, it is very difficult to determine where to direct efforts to stabilize costs, because actual costs, un-shifted, are often not discernable. Future policies should discourage cost shifting and move toward a more honest system of redistribution of health care dollars among various classes of people.

Approaches

We have tried to provide enough information on each of the approaches below to judge its usefulness and feasibility, but we have not delved into the details of implementation, thinking that best left to others. While the long-term cost impact of each approach is discussed in general terms, we have not done any modeling or forecasting of long-term savings or return on investment. Precise cost estimates are not provided: neither are specific funding sources. And for the most part, specific implementing organizations or agencies are not identified. They are not presented in priority order.

Health Status

Of all the approaches the commission is proposing, none are more important over the long run than strategies aimed at improving the health status of Maine's citizens. Focus on health status is critical because it is at the root of future health care costs. "An ounce of prevention is worth a pound of cure."

We put forth three integrally related approaches: focus on communities; shore up the state's obligation to protect the public health; and concentrate on youth. Of all the suggestions we have heard on this issue, we feel that community-based efforts with a special focus on children is the most practical, cost effective avenue. We are suggesting the "healthy communities" approach that brings into account all social, economic, geographic and political elements that affect life for all citizens, accompanied by integrated service delivery. Responding to evidence that Maine's public health capacity is lacking, we offer an approach to build capacity in a modest way scaled to Maine communities and Maine needs. Lastly, we suggest consideration of more attention to children in schools, where the infrastructure already exists and the returns on investment the greatest.

1. Encourage Healthy Communities

Approach

Promote the Healthy Communities approach, which has the following characteristics:

a. Focus on the total community: Involve private citizens, nongovernmental organizations, government, business, and health care providers in considering local social, economic, geographic, and political factors relevant to health.

b. Integrate several systems: The formal and informal community systems that contribute to "healthy communities" include: education, learning, and skill building; safe and adequate housing; recreation and culture; public safety; youth mentors; voluntarism; the workplace; wages; family; nonprofit organizations; health promotion and prevention services; the faith community; the media; and government.

c. Institutionalization: Identify and empower a local entity in each community, one that is accountable for monitoring, planning, and evaluating population-based health indicators and other essential public health services. Perhaps the geographic areas served could be based on the public health districts. Consider redefining the role that hospitals play in local communities.

d. Implementation: The lead entity's staff coordinates local public health needs assessments, data collection, and health planning activities in cooperation with all members of the coalition; develops solutions and finds the financing to implement the plans; and facilitates communication among the partners. The staff normally does not provide direct clinical services. In each community, the work is coordinated with local school health programs and the local public health provider (see other approaches below).

Rationale

Research has shown that health status depends 50 percent on lifestyle and behavior, 20 percent on environment and socio-economic class, 20 percent on heredity, and only 10 percent on medical care and access.[1]

Healthy environments that support shared responsibility enhance healthy choices and thus lessen the impacts of disease. Changes in societal attitudes toward smoking, drunk driving, and wearing seatbelts are good examples of encouraging better personal health choices.

Investing in promotion of healthy behaviors at the community level is extremely effective at reducing overall costs over the long run. Reducing risks posed by preventable conditions is the most cost-effective approach.

Once an individual takes on a healthy lifestyle, it doesn't take long to see substantial savings in health care costs. For instance, a 1999 *Journal of the American Medical Association* study, examined health care costs of individuals over an 18 month period and found that total costs for physically active nonsmokers with a healthy weight were half those incurred by overweight and physically inactive smokers.

2. Establish a Network of Public Health Physicians

Approach

The Bureau of Health should engage a public health medical director for each of the 30 recently established Health Districts. Each director might be a practicing local primary care physician, and might work about a day a week. Those individuals would not provide patient care, neither should they be confused with the current notion of a "health officer." Rather, they would have responsibilities in the following three areas:

a. Emerging Infectious Diseases: Assist in disease surveillance and provide local public health leadership for dealing with emerging infectious diseases;

b. Practice Standards: Promote clinical implementation of evidence-based health promotion and disease prevention interventions.

c. Community Health: Provide linkages for health coalitions on primary prevention, and promote clinician cooperation.

Rationale

In the absence of a formal public health infrastructure, Maine has neither the ability nor a vehicle to effectively identify and react to important public health threats. For example, the Bureau of Health can probably not provide adequate surveillance for emerging infectious diseases such as Lyme disease, West Nile virus, and Group A streptococcus. Whether it has the capacity to provide clinical guidance and public health leadership in the case of widespread disease is also questionable.

Failure to propagate physician knowledge and use of evidence-based health promotion and disease prevention interventions results in less-effective health care provision, which ultimately increases costs to the health care system.

Communities with effective long-term community-based health promotion coalitions that also include clinical providers with public health responsibilities are likely to succeed in reducing rates of chronic disease and other health problems that in turn will result in long term cost savings.

3. Improve Youth Health

Approaches

A. Support school-based health centers. They should coordinate with the Healthy Community coalitions and the public health medical directors (see above approaches), and affiliate with a community-based provider such as a hospital or physician practice. Services provided by the centers might range from treatment of acute illness and minor injuries to screening, referrals and counseling.

B. Support creation of a health council in each school district to focus on:

· Encouraging the participation of parents and youth in policy development and school involvement; including the integration of community providers with schools;

· Supporting the implementation of Maine's Learning Results in the area of Health and Physical Education;

· Providing physical health and behavioral health services including substance abuse services;
· Serving balanced and nutritious food and snacks;
· Promoting work-site health activities that support healthy behaviors and lifestyles; and
· Providing safe and aesthetic physical structures, school grounds and transportation.

Rationale

It has been demonstrated that early intervention and prevention has enormous long-term pay-offs in a society's overall health status. Further, learning health behaviors in childhood translates into healthy habits later in life.

Inactivity and poor nutrition among our youth is a well-documented public health problem. Twelve and a half percent of children between the ages of six and 17 are already seriously overweight,[2] twice as high as the rate 30 years ago. In addition, about 60 percent of overweight children between five and 10 years of age already have high blood pressure or elevated insulin levels, which puts them at risk of heart disease.[3]

Maine's children have unequal access to preventive care in their schools. Some have excellent health programs, but most do not. In fact, only twenty of the state's elementary and secondary schools have school-based health centers.

The long-term overall cost impact of early disease prevention and development of healthy behaviors is significant. There are also immediate cost savings. For instance, Maranacook Community School has had a school-based health center for the past several years and Medicaid costs related to patients in that school district have typically been between 10 percent and 20 percent lower than statewide averages—a discrepancy for which socioeconomic factors do not otherwise account.

Public Policy

Public policies have a major influence on the health care system in Maine. To ensure that those policies are adequately informed by the best possible information and analysis, the state should improve infrastructure for providing useful information and should consider establishing a health policy council to provide leadership, analyze information, develop ideas, and issue reports. Such analysis and data reports would assist the health-related decisions of state and local governments and non-profit organizations.

To improve information not only for policy makers but for consumers, so they can make better choices in consultation with their providers, we suggest considering the establishment of an all claims database, accessible via the worldwide web, that would include charge and paid data, utilization information, and quality indicators.

4. Create a Maine Health Policy Council

Approach

Establish a health policy council to serve as common ground for developing ideas and reporting information useful to policymaking. The council would not regulate activities or control investments in health care services. Its functions would include:

a. Developing health goals for the citizens of Maine to address: health status (perhaps using the Healthy Maine 2010 goals); service capacity and distribution; access and quality of health care; and other issues. The goals could be both quantitative and qualitative, and achievable in five to 10 years.
b. Developing health-related objectives that, if achieved, would reach the stated goals;
c. Preparing a biennial report card on the health status of Maine citizens, as well as on the results of efforts to achieve the council's goals and objectives;
d. Identifying, analyzing, and evaluating alternative approaches to the delivery of health promotion, risk reduction, or health care service programs;
e. Reviewing and revising the commission's principles (see Chapter 4), and using citizen input to determine their most appropriate use;
f. Establishing what constitutes "reasonable access" to health care facilities and recommending revisions to the Certificate of Need process so that it is more proactive, provides incentives, considers a wider range of factors, and is implemented in the

context of a larger vision;
g. Serving as a forum for innovation and emerging approaches, and for researching issues that affect health care costs. Issues the council might consider include analysis of health care staffing with regard to scope of service and impact of shortages in certain disciplines, developing a comprehensive information improvement strategy (which might include the commission's approaches 5, 6, 7, and 8), and emerging questions related to long-term care and death with dignity.

The council might comprise up to fifteen members, a majority of whom should be employers and consumers, i.e. not affiliated with providing health care or insurance. The governor, the speaker of the House, and the president of the Senate should appoint the members.

The council should sunset in six years, its performance evaluated, and reconstituted with appropriate modifications. The council should have a small, nonpartisan staff to provide management and research support. Professional research support should also be provided from a variety of sources. Funding should allow the council to support core expenses and contracts with organizations to fulfill the mandate in a high-quality, professional manner. The council could also be given authority to seek and accept grants from foundations and other sources.

A review should be made of existing efforts with similar missions to achieve consolidation and avoid unnecessary duplication of effort.

Rationale

Nearly five billion dollars is spent on medical care each year in Maine—a majority of that amount paid by government—and there is no comprehensive set of goals and objectives to guide spending priorities and policy decisions, or measures to assess progress toward those goals.

While a regulatory commission does not seem desirable in charting Maine's health care policy, neither is a dearth of organized thought. The commission therefore deems it prudent to suggest a middle ground: a council with power vested in the information it produces.

The council has the potential to reduce replication of endeavors, foster public/private collaborations, and galvanize objectives among diverse interests, thus improving the state's collective ability to achieve goals. Any of those effects would result in slowing the growth of rising health care costs.

5. Improve Information for Consumers and Policymakers

Approaches

A. Develop and maintain an all-payer claims database system that will include charge and paid data, utilization information, and quality indicators. The information should be provided from the database on the worldwide web in a user-friendly format accessible and understandable to consumers, providers and policymakers, and should comply with relevant patient confidentiality laws. Facilitating collection and provision of those data would best be accomplished by working through existing organizations.

Data of at least the following types should be available: charges for procedures; utilization rates; measures of patient satisfaction and quality of outcomes; and patient demographics.

The data should be accessible with breakdowns by provider (hospital, physician practice, etc. – perhaps differing degrees of specificity depending on size of organization), insurance carrier, region (perhaps by public health district), and for the state as a whole.

B. Require all health plans and third-party administrators to provide all claims data on their membership.

C. Require hospitals and physicians to provide information regarding the costs of specific procedures.
a. Hospitals and physicians should be involved in determining appropriate levels of detail, as well as the appropriate format for data reporting.
b. A state agency should be given regulatory author-

ity to establish rules and enforce compliance.

D. Increase the sample size of the Behavioral Risk Factor Surveillance System (BFRSS) survey to make data statistically valid at the county level.

Rationale

Health care consumers and health care policymakers do not have adequate information to make good decisions. Consumers are unable to evaluate providers in terms of cost of procedures, quality of outcomes, and patient satisfaction. And opportunities for community involvement in nonprofit governance are often unknown and or/unclear.

Policymakers often do not have enough relevant data to guide Certificate of Need decisions, formulate insurance regulations, or make other planning decisions. In addition, policymakers are not able to assess the BFRSS data on a regional basis, or by various demographic characteristics, because the sample size is too small.

Improved availability of data would allow individuals and policymakers to consider cost as part of their health care decision making. That would invariably result in lower-cost choices, which would serve to stabilize overall costs. Furthermore, having those data would facilitate the analysis and development of cost stabilization policies.

Efficiency and Quality

Having learned a great deal about how much of the health care system is caught up in administrative-type activities, and having learned that the sheer complexity of the system contributes to medical error, we suggest considering a number of approaches to combat inefficiency and poor quality. Because the current system contains both specific and general inefficiencies, the commission's suggestions encompass both narrow and broad reform.

Among the first steps toward making the system more responsive to the needs of patients and providers would be conducting a statewide pilot of software designed to make individual medical records portable, private, comprehensible and accessible.

Another approach is the establishment of an on-line medical reference system available to all providers, one that would provide state-of-the art, best-practice information to assist with diagnosis and treatment.

Finally, the commission suggests approaches to reduce paperwork requirements for patients, providers, and hospitals: support for the State Uniform Billing Committee; and an examination of the feasibility of third-party certification.

6. Improve Medical Records

Approach

Launch a pilot study of an integrated health information system that allows for individual medical records to be entirely portable among providers, be private, and be accessible by the patient.

The multifaceted pilot project should be implemented as follows:

a. Install VistA/CPRS, or a similar software program, as an integrated health information system for a Maine hospital. That would demonstrate its feasibility, and would provide credible data on cost and effectiveness.

b. Install VistA/CPRS, or a similar software program, for an organization with multiple outpatient sites. That would demonstrate the feasibility and cost-effectiveness of a system that makes patient clinical information available across sites.

c. Develop and test a secure remote medical consumer interface. That project would be the first demonstration of cross-institutional access and control of medical data by medical consumers.

d. Consult with an information-security firm to analyze potential security and privacy problems and the influence of HIPAA (the Health Insurance Portability and Accountability Act).

e. Conduct an independent audit of institutional impact on clinical functioning, billing, and cost effectiveness.

f. Bring together, perhaps through a statewide conference, those interests that are crucial for long-term

effective implementation to examine medical information and privacy issues.

This approach is not intended to tell any health care provider what services to provide or how to provide them; the only requirement of providers is to participate in a shared expectation of how consumer health information is communicated.

Rationale

There is little continuity and uniformity regarding medical records. Patient information is often entered multiple times, contributing to errors and inefficiency. Health care providers have difficulty accessing a new patient's medical history. Consumers do not feel personal responsibility for, or control of, their own medical records. But new models of financing health care, such as "defined contributions," depend upon informed consumers. In addition, new efforts to combat medical morbidity associated with lifestyle issues and chronic illness must involve medical consumers more effectively.

While the feasibility of exchanging health information and improving consumer access to it still needs demonstrating, it has great potential. If successful, it would not only prevent medical errors that result from duplicating information, but would allow consumers to take more individual responsibility for their health. Simplified record keeping would also allow the anonymous aggregation of data, allowing for more relevant research on health issues. A pilot project would provide a wealth of data on cost-effectiveness, safety, and consumer acceptance, as well as useful information for community health efforts and research.

It is estimated that a 20 percent increase in medical productivity would result from installation of effective integrated clinical information systems in health care providing institutions.[4] The epidemiological database created would be extremely important in detecting and addressing new health threats in our communities. As clinical information to support billing becomes more reliable, more consistent in format, and cheaper and faster to submit, the expenditures for administrative costs should decrease. The proposed system would also lead to a significant reduction in preventable patient deaths.

Providing consumers with effective access to information would allow them to take life-style and prevention issues seriously at home—not just at a doctor's office—providing one of the most effective ways to reduce a category of health care costs.

7. Improve Clinical Information

Approach

Improve useful information for clinical decision making, and to allow comparison regarding practice styles and utilization rates. Effective research should be conducted in order to nurture shared decision making, improve quality of care, and advance the scientific basis of clinical practice. Examples include:

a. Develop programs in lifetime learning for health professionals.

b. Focus on population-based monitoring of practice patterns and outcomes of care; as well as on the development and maintenance of an infrastructure for quality, outcomes research, and lifetime learning at the local community level.

c. Disseminate information about clinical practice patterns, successful quality improvement approaches, appropriate evidence-based practice guidelines, and research findings through a database providers could access in their offices.

d. Assist in the development of innovative methods to educate patients, and support shared decision making between providers and patients thus enhancing the patient's role in determining treatment.

Rationale

Physicians and other health care providers have difficulty keeping up with the latest medical developments and information. In many instances, they do not have access to state-of-the-art information technology, which could inform them of diagnostics and outcomes. Even if access to information technology is not a barrier, there is simply not adequate availability or dissemination of information about state-of-the-art quality improvement.

Furthermore, it is often difficult for physicians and

other health care providers to ascertain what is "appropriate care." Such doubt often leads to the precautionary approach of over-prescribing procedures.

A 1992 study estimated that 20 percent of all health care dollars were spent in that year on unnecessary procedures and services.[5] There are also considerable variations in the use of health services across relatively small geographic areas both within Maine and across the nation. Research has shown that providing physicians and patients with accurate information regarding treatment options, fosters shared decision making and results in decreases in variation and improvements in the quality of care.[6]

The approach described above, often implemented by quality improvement foundations, has proven to stimulate moderation in the variations in practice patterns associated with many disease conditions. That, in turn, results in an improvement in the quality and appropriateness of care, as well as in the associated cost of care.

8. Improve Administrative Efficiencies

Approaches

The commission found already underway several promising endeavors that deserve support. We suggest that those interested in reducing health care costs:

A. Endorse and encourage the work of the UB-92 State Uniform Billing Committee to standardize the way in which the UB-92 is filled out.

B. Create a HCFA 1500 Uniform Billing Committee to establish uniformity among medical professionals and insurance companies that use the form.

C. Bring together licensing boards, insurance companies and hospitals to explore uniform credentialing. Specifically, examine the feasibility of third party certification and examine increasing state licensing standards such that insurance companies and hospitals could accept a licensed person with no further credentialing. The work should build on previous similar efforts.

D. Examine the feasibility of sunset review of regulations relating to scope of service for specific professions.

Rationale

As discussed elsewhere in this report, the health care delivery system is fraught with administrative waste. The Critical Insights survey reported that some practice managers claim that "15 minutes out of every patient hour" is spent on paperwork protocols and administrative tasks.[7] In that same survey, hospital administrators estimated that waste and duplication amount to between 15 and 20 percent of all hospital costs. Adding to the administrative burden is the fact that many small providers do not file claims electronically.

Reducing duplicative efforts and streamlining claims and credentialing will achieve savings in the long run without reducing quality of care. In particular, increasing the number of claims filed electronically will increase efficiency.

A note on the Health Insurance Portability and Accountability Act (HIPAA): This is a federal law that will require use of a single form for billing among all those who file claims electronically. However, there are questions about the long -term costs savings of HIPAA. Although the federal government estimates that HIPAA will save $30 billion over 10 years, others estimate that implementing HIPAA could cost that much.

Access

Improved access to health care insurance results in more people getting treatment sooner for existing conditions, and in more people getting preventive care for conditions that may be avoided. In both cases, early intervention is more cost effective than treating illness at a later stage. Furthermore, increasing the pool of insured individuals spreads risk and reduces cost shifting.

An important effort to consider should be to attempt to change federal Medicare policy so that Maine hospitals and other providers get better reimbursements.

The commission suggests that Maine lobby for a more equitable distribution of Medicare funds, improve its submission of data to HCFA, and support efforts to reduce administrative requirements—all of which would increase Mainers' access to hospital care, and would cut costs.

Another aspect of access lies in the ability of individuals to obtain affordable health insurance. For those that are most unable to afford coverage, the commission suggests the state consider expanding Medicaid coverage. We also suggest studying the possibility of making coverage mandatory for children. To make health insurance more affordable, we offer three options: encouraging and facilitating the ability of private insurance companies to cover small businesses and individuals; creating a mutual health insurance fund; and establishing a universal, single-payment program for catastrophic sickness or accident. Lastly, we suggest considering stepping up advocacy for a national financing system.

9. Change Medicare Reimbursement Policies

Approaches

A. Support federal advocacy efforts to improve Medicare reimbursement through changes to federal policy. Work to increase the reimbursement rate for currently covered services, and to expand reimbursement to services not currently covered.

B. Support efforts to improve wage-index and case-mix information submitted to the Health Care Finance Administration (HCFA).

C. Work with HCFA and the Fiscal Intermediary to improve handling of Medicare cost report data.

D. Support efforts to achieve administrative simplification and reduce the financial impact of Medicare's administrative requirements

Rationale

Because rural hospitals are compensated for Medicare services at a lower rate than urban hospitals providing the same care, and because 58 percent of the state's hospitals are classified as "rural," statewide Medicare returns only 80 percent of the expenses incurred in treating those covered by the program. In turn, of course, those hospitals—along with other health care providers such as nursing homes—shift that 20 percent shortfall to other payers.

Increasing Medicare reimbursement rates and expanding the scope of reimbursable procedures would have a substantial effect on cost shifting. It would increase the amount of funding that comes into Maine. And simplifying administration of Medicare reimbursements could result in lowering overall health care costs.

10. Expand Insurance Coverage among Individuals and Small Groups

Approaches

The commission identified three approaches for further study and analysis. While the commission feels it important to take steps to expand insurance coverage among people who are either not covered or have policies through individual or small group markets, the members differ on what approach to take.

10-A: Use three avenues to encourage private insurance companies to cover small businesses and individuals:

The intent of these approaches is to foster the availability of more insurance products and encourage more young and healthy people to voluntarily obtain coverage.

1. Increase flexibility (in rating and otherwise) in the individual and small group markets.

Allow greater rate variations to provide carriers flexibility in addressing health behavior and health problems, and allow greater variation based on age and geographic area. Permit the Maine Bureau of Insurance to allow variations in rate and geographic accessibility standards for a limited provider network when an enrollee has access to a larger provider network that meets current geographic standards. Eliminate "standard" and "basic" health insurance plans

required under the Maine Insurance Code. While those required plans are technically available, and do facilitate comparison among plans, their relative cost has resulted in the sale of very few.

Current rate regulations were designed to provide cross-subsidies wherein individual insurance purchasers would subsidize high-cost users. High-cost users are less likely to be concerned about the premium rate than about having access to an individual health insurance policy. Lower rates for younger and healthier individuals should attract more of them to the market, thereby lowering rates overall.

2. Establish favorable state tax treatment of:
· Health care premiums paid by individuals.
· Medical savings accounts (MSA's) and similar instruments that allow funds to be accumulated for health care expenditures on a federal tax-favored basis, presuming that Congress extends those benefits beyond 2000. Consideration should also be given to requiring carriers in the individual and small group markets that offer high deductible plans to offer MSA's.

3. Collaborate with other states to:
· Pool the individual small group market and enter into joint purchasing alliances. In order to allow maximum flexibility, such a pool may exclude Maine-specific benefit mandates when the mandate is not present in all participating states.
· Streamline insurance regulations and statutes in order to make it easier for carriers to enter the "New England" market.

10-B: Create a mutual health insurance fund to provide coverage to uninsured children, small businesses, and individuals.

This approach intends to provide guaranteed issue in a very visible way, provide an umbrella program which includes Medicaid and thus would minimize any stigma associated with Medicaid coverage, and to create a large, financially stable risk pool with bargaining leverage that would replace, in part, the loss of a major not-for-profit insurance company in the state.

Such a fund might be established as follows:

1. Seek a waiver from the federal government to include the Maine Medicaid program. Use state and federal Medicaid funds: premiums for those populations would reflect differences in expected utilization paid by the state. To the extent that the economic circumstances of Medicaid-covered individuals change, beneficiaries could pay all or part of the premium, and continue participation. In addition to expanding the population base, that approach may serve also to reduce the stigma attached to the Medicaid program, particularly in the eyes of providers.

2. Make the mutual health insurance program open-ended enough so that the state could elect it for coverage of state employees, and so larger corporations and institutions could move into the program if it proved financially attractive. By doing so, the mutual fund might stimulate healthy competition in the insurance market.

3. Seek possible expansion of the program into other states, particularly in New England where interest may exist in making coverage available to similar populations.

10-C: Create a universal, single payment program that protects all citizens from catastrophic financial loss as a result of sickness or accident.

This approach has several intents: to provide catastrophic coverage for all Maine citizens, increase affordability for catastrophic coverage, rationalize health care insurance by pooling catastrophic losses, reduce cost shifting caused by bad debt and charity care, encourage standardization of administrative procedures among all health insurance programs, encourage healthy behavior, and yet allow the competitive market to operate.

It is the most far-reaching of the three approaches, and includes the following:

1. Creating a non-profit company that assumes the risk for medical expenses in excess of a catastrophic limit for all Maine citizens, except those covered by Medicare.

2. Requiring all citizens to have coverage through place of employment, Medicaid or direct purchase.

Because this approach requires an individual, rather than an employer, to have catastrophic insurance, it may avoid constraints imposed by ERISA. The analogy is one of owning a car and requiring the owner to have a certain level of automobile insurance. For those who purchase directly, premiums would be collected annually through state income tax filings and subsidized for qualified, low income persons.

3. Complementing a competitive health insurance industry. Under a catastrophic deductible, the insurance market will be free to develop and promote benefit programs for employers as well as individuals.

4. Increasing affordability of small group and individual insurance programs that underwrite for services below the catastrophic deductible limit.

5. Developing educational and risk management programs that manage health care costs.

Rationale

The recent turmoil in the private insurance market that led to the formation of this commission is in part a market adjustment. In the latter half of the 1990s, health insurance organizations engaged in aggressive marketing and pricing: initial premium costs and increases were very attractive and, as subsequently demonstrated, unrealistic.

In addition, many of the cost reduction strategies employed in out-of-state markets were not as effective in Maine. The absence of competitive provider— particularly hospital—markets in most Maine locations, as well as sophisticated provider organizations that could effectively bargain with insurance companies, contributed to that situation.

While it is clear that recent premium increases are grounded in those factors, there are other structural characteristics of the insurance market in Maine that contribute to costs. Those include:

1. Mandated benefits. Notwithstanding the merits of specific benefits or services, required coverage levels contribute to the cost of health insurance.

2. Prescribed operational requirements. Similar in impact to mandated benefits, requirements imposed on managed care organizations with regard to any willing providers, minimum travel distances, minimum length of stay, and other operational activities represent a regulatory cost to the organization.

3. Segmentation of the insurance risk. Any insurance plan works best when risk is pooled across large numbers. While all insured participants are afforded financial protection, the very high claims incurred by a relatively few number of people are "spread" among all persons who pay an equal and modest premium amount.

That fundamental concept breaks down when subsets (and particularly subsets who have a better experience) of a large pool leave and create their own insurance arrangement. In such cases, the cost of insurance for the residual population in the pool increases, potentially leading to another round of "adverse selection." Those dynamics are at work when large groups of employees select out of a pool under experience-rated or self-insured arrangements; insurance companies selectively market to the better risk; and healthy individuals decide not to buy insurance.

Such segmentation creates significant variances in the cost of health insurance among different populations: typically small groups and individuals represent the residual populations that have been shifted against. To the extent that individuals and employees in small groups defer insurance because of cost—and then incur the need for services—a very significant financial liability is incurred, as is bad debt and charity care for providers. Those latter costs are often shifted to other private insurance payers.

Generally speaking, more Maine people with adequate health insurance coverage would result in lower long-term health care costs because people with coverage are more likely to seek medical care earlier, which most prevents the need for more costly treatments.

To the extent that each of the three approaches would result in increased coverage, the cost impacts vary.

11. Expand Health Care Insurance for All Children

Approaches

The commission puts forward two complementary approaches.

A. Improve Medicaid and Cub Care coverage of children in the following ways:

1. Improve enrollment in existing programs. This could be done by continuing efforts that have resulted in recent positive enrollment trends, as well as by increased outreach and awareness at places frequented by children such as schools, pre-schools, hospitals, and the offices of health care providers.
2. Expand Medicaid coverage to maximum levels allowed by federal law. This could be done by amending the state plan to cover children in families that currently earn too much money to be eligible.

B. Mandatory coverage of all children, with an emphasis on prevention. Codified in law, all Maine parents would be responsible for providing health insurance for their children. . An affordable policy should be available: one that covers basic screening, immunizations, and preventive services. The last should be available through school-based programs where possible and reimbursable.

Rationale

Many Maine children are not receiving appropriate preventive care because they don't have health insurance, their parents are otherwise unable to pay for care, and free care is not available to them. Access to insurance would dramatically increase children's access to health care, especially to preventative measures that prevent further illness and associated health care costs.

Even if Maine has the second largest percentage of insured children in the nation, 18,000 children without insurance is still too many. Furthermore, Maine children are not as healthy as they could be, and many have poor health care habits. Teaching them healthier ways of living now would result in individual and societal rewards later. Investing in them results in a greater long-term return than investing in other groups. And the infrastructure, namely the public schools, already exists to facilitate deliver of preventive services.

The cost of covering Maine's uninsured children is small relative to future cost savings as a result of early screening, disease prevention, and development of good health care habits. Investing in the protection of Maine's children from disease would mean the state would need to spend much less money down the road to ensue a healthy workforce. And that is an investment from which the entire society benefits.

12. Expand Medicaid Coverage

Approaches

A. Amend the state plan to provide Medicaid coverage for all adults below the federal poverty line, based on a reasonable timetable in light of budgetary constraints.

B. Increase Medicaid reimbursement rates of certain under-funded procedures.

Rationale

Data shows that lower income people are disproportionately in poor health and are less likely to be able to obtain insurance in the private sector. In a recent survey covering three Maine counties, 21 percent of adults with incomes below the poverty level reported "fair" or "poor" health, compared to 5 percent of adults with incomes between 201 percent and 300 percent of the poverty level.[8]

Other studies consistently confirm that health insurance for low-income people is a critical factor in their health status.[9] Thus providing health insurance for the uninsured is an important factor in stabilizing costs in the private sector.

When asked the most effective way to extend health insurance to the uninsured, absent a complete overhaul of the system, experts who spoke to the commission invariably responded that Medicaid was the most realistic and cost-effective route. The com-

mission also heard that low Medicaid reimbursement rates cause providers in some disciplines (e.g., speech and occupational therapy and durable medical equipment) to refuse service to Medicaid clients, thus exacerbating the access problem faced by low-income individuals.

When low-income people obtain free care in hospitals, or from other providers, those costs are passed on to insurers, and ultimately, to payers of insurance premiums. In 1998 Maine hospitals spent $29 million on charity care and another $71 million in bad debt.[10] Coverage for all the uninsured—and underinsured—would eliminate the shift of those costs to the private sector. The expenditures would be covered and would ameliorate the inefficient and expensive system of treating the uninsured in the emergency room—often after a minor health problem has progressed to a major one. By investing $5.2 million state dollars per year, Maine would gain an additional $10 million in federal matching dollars—and would provide coverage for those who qualify for charity care, and are least likely to be able to pay their bills.

13. Advocate for a National Financing System

Approach

Advocate for a national health care financing system with other states. Such a system should have the following characteristics:

a. Universal health care coverage.
b. A decentralized delivery system, governed by states, but based in the market to allow for consumer choice.
c. A single nonprofit payment source, though perhaps decentralized claims administration.

Potential activities:

1. Convene the state's congressional delegation, and perhaps special interest groups, to develop an agenda and strategies to use at the federal level.

2. Convene New England governors to discuss strategies and develop a common agenda.

3. Encourage passage of proposed legislation currently being considered by congress that would allow a limited number of states to experiment with a single-payer system.[11]

Rationale

The commission came across several problems with the current system, all contributing to increased costs, that would be addressed with the establishment of a system of central financing and universal coverage. Such a system would:

- Reduce cost shifting
- Shrink administrative waste
- Provide transparency
- Improve fairness
- Increase access
- Provide for true shared risk (community rating)
- Aggregate data
- Allow for global budgeting

The commission found, as did the Health Care Reform Commission of 1995, that it is not feasible for a single state such as Maine to establish such a system alone. But the members do feel that Maine could join with others to promote a national system.

To the extent that a central financing system would reduce redundancy and administrative waste, reduce cost shifting, improve access, and fairly distribute risk, the cost impact could be enormous.

[1] Mills, Dora Anne. "Chronic Disease: The Epidemic of the Twentieth Century." *Maine Policy Review*. 9.11(Winter 2000):
[2] National Health and Nutrition Examination Survey, Centers for Disease Control and Prevention, 1999.
[3] A. Wolf, and G.A. Colditz, "Current estimates of the economic cost of obesity in the United States," *Obesity Research*, 1998;6(2):97-106, quoted in *Priorities in Prevention: Excess Weight and the Obesity Epidemic.*
[4] Medical Information Trust of Maine, correspondence to the Commission, October 14, 2000.
[5] "Wasted Health Care Dollars." *Consumer Reports.* July 1992.
[6] Maine Medical Assessment Foundation, October 17, 2000.
[7] Critical Insights, *op.cit.*
[8] Ormand, Salley and Kilbreth, *op.cit*.
[9] See generally, *No Health Insurance? It's Enough to Make You Sick, op.cit.* .
[10] Pohlmann and St. John, *Within Reach, Health Coverage for Working Parents (*Maine Center for Economic Policy, 1999)
[11] H.R. 4412, 106th Congress, 2nd Session.

Chapter 6
FINAL COMMENTS

We each offer the following final comments because, while we learned a great deal together and developed many shared perspectives, we none-the-less developed some individual opinions we thought worth sharing. These individual comments emphasize various aspects of the report, and in some cases, register disagreement with certain aspects.

Final Comments of Pam Plumb

Serving on the Blue Ribbon Health Care Commission has been an extraordinary education on the state of health care in our state and country. Dozens of thoughtful, committed health care professionals and experts in the field have patiently served as our teachers, sharing their knowledge and opinions. They brought us mountains of information and a wide spectrum of opinions.

After all the presentations, reading and discussions a few things, in particular, stood out for me. First, Americans pay far more for their health care per person than the nearest competitor for the title of most expensive, Canada. Most of the world spends less than half of what we do. We cherish the myth that we are getting much better health care for our money. In some areas, such as advanced medical technologies, we are. However, when it comes to the general health of the whole population, we are lagging well behind. It is not acceptable that we are spending so much and still not keeping the American people as healthy as the residents of many other nations.

Second, although there are some distinct features to the health care in Maine, such as its rural nature, the aging of the population and the number of smokers, the causes that make health care so expensive in Maine are the same as those for the rest of country. The systemic problems are national in scope. The state of Maine alone will be unable to make the kinds of systemic changes that are needed to significantly impact costs. The need for national change is my greatest frustration with this report, which is, of necessity, focused on Maine with less than .005 percent of the nation's population. We have recommended what we felt could impact and improve the cost of health care in Maine, but the real opportunities for change lie at the national level and we should become active advocates for change.

Third, in our current health care system, where 1) the person receiving the service most often does not pay directly for it and often doesn't know the cost, 2) providers often compete on how much modern equipment they have rather than price, 3) fees for service are related to reimbursement schedules rather than cost, 4) the services are generally a mystery to the patient and often overlaid with the emotions of life and death, 5) marketing drives demand for services or medications which may not be necessary or appropriate, the private market system doesn't have a chance to work. Contrary to the normal laws of economics, in Maine at least, competition is generally driving costs up, not down. There are certainly a few areas in health care where market competition may work, but unless we change the system dramatically, it won't work generally. We are the only country in the world trying to run our whole health care system on the private market system and the only industrialized country not insuring health care for

the entire population.

Last, even though our charge was to find ways to reduce costs in health care, it is impossible to discuss the subject without running into questions of access and quality. In fact, one of the ways to reduce costs is to force everyone in the pool, which would better spread the risk and reduce the number of people not getting preventative care. But, it is more than a question of cost for me. It seems morally unacceptable to me that we cannot find a way to provide basic health care for everyone. This country has looked more than once at national systems to accomplish this basic task, but has not had the political will to carry it off. We must make the issue central to the political debate so that it is resolved.

Final Comments of Thomas Moser

At our first meeting on February 4, 2000 we were told by Dr. Robert Keller, the chairman of the last commission to study health care in Maine, that normal market forces don't work in healthcare and all must be covered for insurance to be effective. As a champion of Adam Smith and a strong advocate of the free market I didn't buy it at the time. Now, eight months and 22 meetings later I have come to see certain wisdom in this.

One hundred and fifty year's ago public education in Maine, as in the rest of America, came to be seen as a right of citizenship. Our political leaders came to realize that only an educated electorate can make informed choices and our democracy could not prevail without such public funding to augment private schooling. Although we may argue over public schools versus vouchers, nobody of sound mind would argue against public funding for universal education.

That moment in our history was pivotal and set the course for an economic and cultural journey unimagined in the Old World where privilege determined access. Might we now be at a similar moment vis-à-vis healthcare? Might we as a people be ready to fund and define universal healthcare? Do not confuse fund with deliver, they are vastly different, for the former uses principally the power to tax while the latter performs the service. Look how close congress is to funding pharmaceuticals for those over 65; this would not have happened 10 years ago. Its called "readiness" and we are getting ready.

In the early pages of this report we assert that…"Our values endorse the notion that an individual has the right to receive whatever services are necessary in times of need." The phrase "whatever services are necessary" is arguable but who is so bereft of spirit as to take issue with this concept of compassion? What is at issue is the means of provision, not the necessity for providing.

Then a bit later we write…"A national single payer system may be the only approach that will work to control costs, assure access and rationalize the delivery of health services." As a strong advocate and practitioner of free enterprise it came as quite a revelation that we are over halfway toward the single payer system already when one factors in the reality that employer funded medical insurance premiums are paid with pre-tax dollars.

Throughout this report we speak of administrative expense which we believe consumes one-quarter of every dollar spent. Of the two billion dollars paid into the system by insurance companies 15% goes to their expense ratio. It cost these carriers at least $300 million to collect the premiums; the IRS, on the other hand, spends about 2% to collect the revenue to fund both Medicare and Medicaid. Nobody disputes the cost effectiveness of the IRS. The legislative challenge, however, will be in crafting a set of laws for the distribution of these funds by federal and state agents that will be less onerous than the whipping boy known as the HMO. We have to craft Federal and State programs that allow sufficient regulation to guarantee equitable coverage while at the same time providing for differences of access, based upon the individuals ability to pay. This same system must also be able to leverage behaviors, i.e., destructive life style choices should result in some negative consequences while wholesome life style choices should reward the individual with more than just longevity.

In the meantime, there is much that Maine can do to address many of the issues we've raised. Ultimately, however, our salvation is in a National single-payer system.

Final Comments of Joe Carleton

I would like to thank my fellow Commissioners, especially our Chair, for the collegial manner in which we were able to conduct our work. We have learned much, and although we do not agree on everything, I think we can advance public understanding of this very complex issue.

People look for magic bullets to save our health care system. There are no magic bullets. There are, however, magic words. Words like "competition" or "single payer" or "HMO" magically cause minds to close, tempers to rise and voices to shout. We need to forget magic bullets and magic words and go way back, back to some of the basics, to get our bearings about what health care means in this country, what a health care system can and cannot do and where it should fit in our lives. What follows are things that I think get too little attention. Our ignorance about these things is the single biggest impediment to a good health care system, in my view.

1. Health care reform needs to be undertaken very carefully. During its meetings, the Commission heard and frequently referred to the "balloon theory" of health care. Health care is like a balloon, the theory goes, because poking the balloon in one place will simply cause it to expand out someplace else. The health care "system" is many different systems acting independently, interacting with each other in unpredictable ways. Poke it in one place and something strange happens somewhere else.

2. Private insurance and government benefits increase costs. Ten friends dine out, intending to share an inexpensive meal and good conversation. To make things simple, they ask for one bill and agree to split it equally. A waiter, hearing this and knowing he will make more money by serving an expensive meal, leans down and whispers to each patron in turn, encouraging the diner to order a filet mignon or a lobster dinner. The waiter explains to each person that since the total bill is split ten ways she will pay only a small portion of the extra cost - 90% will be paid by others in the group. All people in the group make an individual decision to order costly meals. Pooling the bill has led to expenditures that no one of them would have chosen had they acted alone. As former Surgeon General C. Everett Koop once said about the bill pooling device known as health insurance, "It's like saying to someone, 'We are buying you a new car. Now what do you want, a Cadillac or a Chevy?'"

3. Health care is a business to the providers of health care. We all know that our medical care providers are caring people, but hospitals and doctors and other health care providers are not immune from the economic incentives that affect everyone else. This is true even for "non-profit" institutions who, after all, need resources to continue provide their services. We oftentimes forget that the usual economic incentive in health is to provide treatment. This frequently results in care which is costly, not medically necessary, and perhaps even harmful.

4. Providers of health care are fiercely protective of the turf carved out for them by licensing laws. This fragmentation increases costs. Many providers wage huge battles among themselves, played out in the Legislature, over the scope of practice allowed to them by the state. State boards are made up mostly of practitioners in the fields they regulate, and they have an incentive to keep a monopoly. A few years ago Medical Care Development Foundation sponsored a study of licensing laws. This field ought to be looked at again.

5. Health care will drain every available public and private dollar unless restrained. This is so because:

a. Health care is more art than science. Therefore, health providers have wide discretion in treatment. Different health care providers do prescribe widely varying treatment. The first witness before the Commission, Dr. Robert Keller (who chaired the previous health care commission) emphasized how some medical treatments are much more common in some geographical areas than others. All this is well known and has been extensively studied. Many of the pioneering studies have been done right here in Maine.

Furthermore, the type of treatment prescribed by health care providers varies widely with the health care provider. Chiropractors will generally prescribe chiropractic for back problems, M.D.'s will prescribe treatment within their scope of practice, and so forth.

b. Demand for health care is potentially limitless. Should an expensive diagnostic test be performed if there is a very small likelihood that it will be helpful.? How small is "very small"? One in a hundred? One in a thousand? One in a million?

c. Increased supply of health care providers creates increased usage of those services. Health care providers determine how much health treatment and what kind of treatment should be given. They have much discretion about this because health care is more art than science and the patient doesn't mind if the bill is covered by insurance (public or private).

Here are some summary thoughts about common myths:

a. Beware those whose solution to the high cost of health care is to have someone else pay for it.

b. Beware those whose solution to the high cost of health care is to put themselves into a group likely to have low health care needs, resulting in lower costs for them but higher costs for everyone else.

c. Beware those who judge our health care systems solely in terms of the numbers of people with or without health insurance. These statistics can be misleading and are often selectively used.

d. Beware those who demonize the insurance companies, or drug companies, or the government as the cause of problems with our health care systems. The truth is much more complex. The nearest culprit can be found by looking in the mirror.

e. Beware those who argue that health care decisions should be solely between a doctor and a patient. This statement has an appealing ring to it and would be true if the patient paid the entire bill, but this is rarely the case. Insurance payments represent the pooled resources of many policyholders and public benefits come from taxpayers. They have a stake in making sure the financial resources they provide are used wisely.

f. Beware talk about people getting all the health care they "need". Need can be a very slippery concept in health care. We can probably all agree what health care is needed in some circumstances, but beyond that, need has to be tempered by the finite resources available.

Here is my reaction to two common approaches to control health care costs.

1. Let the competitive free market work! Competitive markets, which work so wonderfully in other areas of our economy, do not work very well in health care for several reasons. Insurance (private or government) insulates the consumer from much of the cost. In addition, the complexity of health care means that the health care providers instead of consumers make most of the decisions. The provider has an economic incentive to increase services and therefore increase costs. We are unwilling to place limits on what the provider can prescribe. Also, personal health is a matter of such high personal priority that we want health treatment, no matter how unlikely it is to help and no matter what the cost is. We willingly accept the price charged. Finally, supply creates demand, as Dr. Keller suggests.

Health care providers do not advertise their prices. This is an excellent clue that free markets don't work in health care. There are no newspaper or radio ads saying that the hospital or doctor offers great prices. Although hospitals and other health care providers compete, they don't compete on price. Perhaps markets can be adjusted to provide better price competition, as Commissioner Beardsley suggests, but it hasn't worked so far and it will be difficult to do.

2. Health care needs to be regulated! When a patient and a doctor are in the examining room discussing treatment, neither of them cares about cost. The insurance company and the government (who will be paying all or a portion of the bill) are not in the room. The doctor has considerable discretion in treatment. The field of medicine is very complex. Patients feel very strongly about their right to care. Medical technology is changing rapidly. This means that regulations (either by the government or an insurance company) are complicated. General rules will necessarily have loopholes and exceptions, which in turn require more rules to deal with them. These in turn

give rise to further loopholes and exceptions. What can result, and has resulted, is an army of clerks battling each other over mind boggling minutiae as well as forests of paper filled with incomprehensible jargon, some of which must necessarily be labeled "THIS IS NOT A BILL."

Inadequacies of the market and regulatory approaches mean that we ought to look for other models. The Commission report has listed a single payer system as an alternative to look at. Some Commissioners have gone further and recommended that a single payer system should be enacted on the national level to address the inequities of the present systems.

In light of the charge given to us by Governor King to address costs, I suggest that one approach, known as global budgeting, allows us to make a conscious decision about the resources we spend on health, so that we don't end up like the friends who paid more for their restaurant meal than any of them intended. The decision about how much to spend on health should be under our collective control, as it is not now.

Providers of health care under global budgeting need not be subject to detailed rules and regulations set by insurance companies or the government. A designated sum of money is collected and allocated for health care expenditures within their geographical area. Health care providers make decisions about how this money is to be spent, keeping within the budget, without detailed regulations.

Commissioner Beardsley and I strongly disagree with inclusion of the approaches set forth in paragraphs 11 and 12 in the Commission's report, relating to expansion of Medicaid programs, for the following reasons:

1. Medicaid expansion may reduce costs in individual cases where discovery of a health condition in its early stages will prevent more expensive treatment later on. This does not mean that it will stabilize or reduce overall costs, short term or long term. I am sure that it will not.

2. Although the scope of Medicaid programs is a significant issue, there is already wide public debate about it. There is much value in a report that focuses solely on the cost of health care. Paragraphs 11 and 12 blur that focus.

3. Medicaid has a significant impact on the state budget. It is presumptuous of the Commission to suggest how the myriad demands on the state budget should be prioritized. This is the job of the Governor and Legislature.

Final Comments of Bill Beardsley

A Minority Report by William H. Beardsley is attached to this report.

Final Comments of Robert Woodbury

The five members of the Commission, over hundreds of hours, shared good will, much learning, vigorous debate, and uncommon commitment. We sometimes differed and sometimes changed our minds. But I will always be grateful to all my colleagues, and Governor King, for providing a very special opportunity. I hope our collective thinking will be helpful in the larger debate about health policy in Maine.

One issue, finally, stands out for me amongst all others: the extent of inequity and unfairness in our health care system. The uninsured and other people of limited means, numbering in the many tens of thousands in Maine, receive second class health care at best and experience tragic denial at worst. This reality not only diminishes our values as a community but inflicts extra costs on our health care system as a whole.

Some have suggested that proposals for the expansion of Medicaid or other health services lie outside the scope of our charge. Considerable evidence exists, however, that delayed medical attention, inad-

equate preventive steps, and treatment sought in hospital emergency rooms escalates costs. Removing financial barriers for the less advantaged may diminish overall costs to the system and lessen cost shifting. Expenditures by state government in the short run, therefore, whether for Medicaid or public health or information gathering, may bring some long run stabilization to health costs as a whole. There is much we can do in Maine to diminish unfairness that is wholly consistent with controlling costs.

But the best strategy for addressing fundamental inequities in the system lies at the national level. I am persuaded, as I was not nine months ago, that only a national and universal financing system "with broad pooling of risks and progressive financing", as Consumer Reports concluded in its September 2000 issue, can both ameliorate the consequences of unfairness in our current system and address some of its most wasteful aspects. That would still leave a large agenda for Maine and its communities, as we have suggested throughout our report, in making the system work in a cost effective and humane way.

A MINORITY REPORT OF THE YEAR 2000 BLUE RIBBON COMMISSION ON HEALTH CARE

William H. Beardsley

November 15, 2000

EXECUTIVE SUMMARY

The Report of the Maine Blue Ribbon Commission on Health Care is comprehensive. It is based on broad input and substantive analysis. It proposes a significant increase in public expenditures and public sector involvement rather than cost stabilization. Cost stabilization was the charge to the Commission. This minority report is focused on cost stabilization.

The minority position is that Maine can and should take steps to stabilize health care costs by moving towards a consumer based, market driven, health care system. Policies recommended include:

· *Tax credits or deductions for premiums on catastrophic insurance*
· *Replacement of the employee state single payer system with a federal style multiple payer system*
· *Elimination of, or significant curtailment of, the certificate-of-need process*
· *Elimination of barriers to entry for qualified providers*
· *A sunset review of state licensing procedures*
· *A comprehensive review of barriers-to-entry regulations*
· *Targeting of data collection on epidemiological studies*
· *Consolidation of health boards and commissions*
· *Acceleration of moves towards standardization of billing and authorization*
· *Establishment of a task force to develop a multistage strategy to move Maine towards a consumer based, market driven health care system.*

A MINORITY REPORT

Governor Angus S. King, Jr., established a commission to identify cost elements of Maine's health care system, how cost are allocated, and to "recommend potential strategies for stabilizing overall health care costs"... and "payment options for health care services."

Collectively, the policies recommended in the majority report propose an expanded public planning, policy, and regulatory role, an increase in Medicaid expenditures, and an expanded role for quasi-public and private health policies agencies. Rising insurance premiums, the contraction of HMO's, the need for more health information and effective policy formulation, the chronic under-coverage of Maine's population, shortfalls in reimbursements and the perceived value of health education have given the Commission a rationale for proposing an array of policies that lead to a significant increase in public expenditures.

Further, the cost analysis of health care in Maine, as presented, is a valuable building block and the discussion of cost drivers and principles reflect the views of various constituencies with whom the commission met across the state. The final report provides a frame of reference for policy discussion and a broad database upon which to build in future years.

The minority member of the commission has the highest regard for fellow commissioners, the open process, the in-depth background cost analysis and the discussion of cost shifting, cost drivers, and the need for future research. The recommended majority policies, however, do not fully reflect commis-

sion deliberation. At the most fundamental level, the report states that "our culture is unlikely ever to accept market dynamics alone to resolve fundamental issues as they relate to access, availability, and affordability…" (p.6) This underlying philosophy permeates the report and has necessitated a minority report.

At the outset, while the primary purpose of the minority report is to set forth recommended steps to stabilize health costs, there are other concerns that should be mentioned.

· The report recommends that Maine schools become a major vehicle for delivery of health care services. Given current funding problems and the sheer complexity of providing quality education, legislature should be very cautious in adding another major function to an already burdened school system.

· The report recommends a significant expansion of Medicaid services while at the same time documenting the massive growth of, magnitude of, and high cost per recipient of the Medicaid system. Legislature should weigh very carefully the allocation of additional state resources to Medicaid vis-à-vis other citizen needs.

· Cost differentials and trends in different geographic locations, as presented, leave inferences about the effect of over-capacity, competition and HMO's on costs that are questionable and overlook such explanations as the percent of a provider's client base that is on Medicaid and Medicare, case mix, and differentials in Medicaid wage indices. To date, there is not enough analysis to legitimately set forth conclusions.

· There is a staff propensity to include such advocacy terms as "health is a birthright," "environmental health," and that "a national, single payer system may be the only approach that will work to control costs." These positions were not fully addressed or resolved by the commission.

In general, it is a minority belief that recommended policies of the report fall well outside the charge to the commission, at best, and could exacerbate the very cost problem the commission was established to address. The charge was to stabilize health cost, not to set forth a plan for expanded public expenditures. This minority report offers no "elegant solution." Rather, it proposes a very different array of policy recommendations for consideration, recommendations which could help to stabilize costs and lead towards a more consumer oriented, market driven, health care environment in the long run.

General Observations

1. Health care costs in Maine are higher than in the past and not unlike the national statistics both in levels and in trends. Similarly, Maine's health care challenges are numerous and similar to other states: costs are rising faster than incomes, cost shifting leads to inequities, and segments of the population are under-served.

2. There is a highly regulated, evolving, expansive system of providers, payers, consumers, policy advocates and regulators with very complex interrelationships, operating in a quasi-free-market/quasi command-and-control environment. The vested interests are extraordinary and persuasively argue for more public funds injected into the status quo, offset by public policy groups and soft money consultants who offer an extraordinary array of ideas, ideologies, and services.

3. Currently, there are very positive trends concerning Maine's uninsured. The percentage of Maine's children that are uninsured has declined from 16 percent in 1995 to 5.9% in 1999, placing Maine among the top four states in the nation in terms of child coverage. The percentage of overall uninsured has also declined significantly. The general public is more informed about health care costs, healthy living, insurance and public subsidies than in the past and appears to be making ever better choices, as are providers and payers. The system appears to be improving.

4. There is little evidence that health care costs as a percent of the gross state product (at about 14%) should decline. However, there is considerable evidence that partially funded federal mandates, state regulations and policies, and an array of "soft money" organizations and the vested interests of the status

quo providers and payers, have collectively made change in the direction of a cost effective, consumer based market driven system very difficult.

POLICY RECOMMENDATIONS FOR STABILIZATION OF HEALTH CARE COSTS IN MAINE

I HEALTH CARE PREMIUMS

Background: Lower income and elderly consumers benefit from Medicare and Medicaid but reimbursement levels are largely below provider costs. Large employers have negotiated very competitive services. That leaves individuals and small businesses as the residual consumers. The resulting economics dictate that providers therefore must load up these "residual consumers" with most of the overhead costs. This drives up premiums to a point where the lower income self employed and employees of small firms are priced out of the market. These uninsured/under-insured consumers may go without care and/or go to hospital emergency rooms for charity service which hospitals are required to provide. These hospital charity costs are then passed on to individual policyholders and small businesses in the form of yet higher premiums. One solution is to take steps to help make the market work more effectively by more closely tying costs to benefits for the paying and charity consumer alike.

Policies to Stabilize Health Insurance Costs and Reduce Cost Shifting

1. Establish a state personal income tax credit or deductions for the purchase of high deductible catastrophic insurance, targeted to those most in need. The goal is to use incentives, not prescriptive measures, to help consumers meet their greatest insurance need. This would make insurance more affordable to at least one segment of the uninsured.

2. Eliminate the single insurer policy for public employees and replace it with a federal-employee style array of choices thereby establishing a large insurance pool for competitive insurance plans. This new markets will attract insurers. The goal is to create a greatly expanded individual insurance market, promote competition and economies of scale.

3. Seek Maine's fair share of Medicare funds and apply it, first and foremost, to adequate reimbursement levels. The goal should be to reduce provider cost shifting and, hence, reduce insurance premiums to non-Medicare/Medicaid consumers. This Medicaid shortfall may be as high as $100 million.

II MARKET FORCES

Background: Barriers to entry for health providers exist at all levels in Maine. The resulting collective inefficiencies are significant. Each barrier, however, has a strong constituency and vested interest; hence, the array of constraints-on-trade is often presented in the guise of consumer protection.

Policies to Reduce Constraints-on-Trade

4. Eliminate the Certificate-of-Need process. It has failed in Maine; it stifles innovation, limits competition, restricts entry, and discourages creativity. Greater Lewiston/Auburn has the same population as Rochester, Minnesota (75,000) yet there is little doubt Maine's CON process would never allow a Mayo Clinic. Direct and indirect costs of the CON process are significant. If CON is eliminated, it is also critical to eliminate such mandates as charity care/24 hour care that have historically accompanied CON approval or cost inequities will occur.

5. Enact "all qualified clinical provider" legislation. For each consumer's clinical need, Maine should remove regulatory and other barriers to provision of such services by the least expensive "qualified" service provider be it nurse practitioner, medical assistant or whomever. For example, only Anthem will reimburse many allowed nurse practitioner services rendering it difficult for an N.P. to establish a free standing rural practice. Harvard Business School studies and economic principles suggest that such artificial barriers to entry are a major cause of health cost inflation and lack of access in rural areas.

6. Enact "consumer protection" licensor legislation. There is evidence that the licensing process in Maine has evolved into a "professional-protection" system rather than a system to "encourage entry" and "consumer protection." A comprehensive sunset review of all state licensing statutes and regulations related

to health care is recommended for consideration.

7. Enact "constraint-of-trade" review legislation. State laws, regulation and practices are rift with artificial barriers to competition and entry. To illustrate:

· the state offers education loan forgiveness to veterinarians but not to nurse practitioners and physicians' assistants in shortage areas.
· medical assistants may report to physicians but not to qualified nurses and may not carry out such duties as making beds in hospitals without redundant CNA qualifications.
· new regulations offer dentists in shortage areas loan forgiveness but only if they agree to provide "free" service, a policy which favors salaried public-clinic dentists over fee-based private dentists.
· physicians and nurse practitioners are limited in their ability to develop partnerships, as they are "unlike-professions."

8. De-massification of health care. While Maine is fairly progressive, there are barriers to telemedicine, mobile health services, non-traditional (often un-reimbursed) services, especially in rural areas where, isolation magnifies the cost of traditional service. The state should be proactive in establishing incentive rather than prescriptive legislation/regulation that would minimize barriers-to-entry for decentralizing technologies, especially for rural Maine. FAME style loan guarantees and/or subsidized loans should be considered as an incentive for investment in new technology.

III EFFICIENCIES

Background: There is a wide array of government agencies, licensing boards, commissions and other quasi-government entities with health care responsibilities and/or interests. There is limited formal interface between these groups. There are separate data collection efforts, limited standardization of procedures, challenges of redundancy and overlap. Much of the public session input to the commission was lobbying for contracts and more funding for planning, analysis, data collection and staffing rather than cost relief for consumers. The majority report addresses this by proposing the addition of a new oversight council. The minority report would prefer further consolidation.

Policy Recommendation in the Area of Efficiencies

9. The state should consider significant health agency consolidation and overhaul of its health responsibilities. Areas for consideration:
A. The state should consider having Medicare/Medicaid administered by a neutral third party much as FAME administers student loans. The goal would be to build a firewall between allocation and advocacy.
B. Basic data collection should be centralized in an existing central planning function such as the State Planning Office. The goal is to "mainstream" heretofore isolated and non-comparable health and demographic data.
C. While Maine has done a good job consolidating health departments and bureaus, boards and commissions should undergo a sunset review with a view to consolidation. This could be mandated by legislation or encouraged through an informal Governor's Kitchen Cabinet for Health not unlike the Kitchen Cabinet for Children.

10. A comprehensive review of opportunities for cost efficiencies should be undertaken. Areas showing promise include:
A. Protocols for standardizing the way uniform billing forms are filled out with a focus on U.B. 92 forms hospitals fill out for insurers and the federal HCFA 1500 Uniform billing procedure.
B. Protocols and incentives to replace pre-certification with post-certification by insurers for approved providers. For example, addressing this issue could be a positive consideration in bids for state insurance contracts.
C. Develop standardized application procedures for statewide approval for practice privileges and uniform credentialing. Such standardization does not limit a hospital or clinic's right to withhold privileges but it could reduce bureaucratic obstacles in the process.

IV LONG TERM COMPLEX STRUCTURAL CHANGES

The State of Maine should consider a strategic long-term objective of moving towards a consumer based, market driven health care insurance system as a prototype for the nation. At the heart of the transformation would be very difficult but worthwhile shifts including, but not limited to:

11. Elimination of tax deductions for health insurance premiums for corporate income tax but only if there is a concurrent revenue-neutral shift of responsibility and resources to the consumer. Since corporations usually have community rating policies, current employees have very diverse health benefits. Those diverse levels of benefits would probably have to be passed on to individuals at the outset to avoid adverse selection and the transferred funds would probably have to be used for insurance. Federal ERISA regulations must also be addressed. A task force to address such a potentially bold solution should be established.

12. The practice of mandated charity obligations for some but not all health providers creates massive cost equity distortions and should be phased out concurrent with direct consumer-based-assistance centered on consumer need and responsibility.

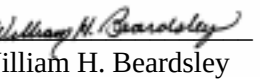
Finally, the market works best when information and price signals are available. Too much information, however, especially if mandated, can be counter productive and add expense. If one were to use tobacco settlement money to collect information that would most likely improve the functioning of the market, that investment could well be for much needed epidemiological studies.

13. Epidemiological Studies. The state should establish and annually update a detailed epidemiological report that is geographical, socio-economical, and demographically specific. It should be produced independently of any advocacy agency or group and must be of sufficient quality to provider, payer and public policy interests to be useful in substantive decision makers. The State Planning Office, as a candidate for this work, offers many advantages as it also collects, analyzes and reports on non-health data.

14. Pricing Information. Legislation should be enacted and some funding should be made available to industry associations to establish a voluntary, formal, yet understandable, pricing disclosure system for consumers. Failure by the providers and payers to achieve such a standardized disclosure system could/ should lead to a government action to do the same.

15. Medicaid Reimbursement. Under-reimbursement in Medicaid appears at the root of cost shifting in Maine. Medicaid can be improved with no increase in funding. The state should mandate that Medicaid reimbursement cover what the state deems to be reasonable direct costs of service, adding funds where too little reimbursement is currently available, cutting back on marginal consumers if that is the only way to achieve at least "minimal reimbursement." The entire administration of Medicaid in Maine needs an in-depth review. In Maine, Medicaid expenditures exceed $800 million. This does not imply there are known problems but rather its rapid growth and sheer size needs to be assessed and rationalized for the citizenry's peace of mind.

Signed by:



November 15, 2000

William H. Beardsley Date

Appendix A
Cost Profile Technical Notes and Tables

Table 1
Summary of Estimated 1999 Personal Health Expenditures in Maine

	for populations whose primary insurance is:						
	Medicare	Medicaid	Dual Eligibles	Private Insurance	Uninsured		Total
					Subtotal	Adjusted	
Population	173,333	138,420	37,667	746,180	165,440		1,261,040
Hospital Care	$ 427,977,317	$ 298,452,056	$ 150,043,097	$ 741,445,832	$ 115,073,252	$ 10,073,252	$ 1,627,991,554
Physician Services	$ 189,085,161	$ 33,683,403	$ 43,568,947	$ 496,228,250	$ 77,015,199	$ 38,507,600	$ 801,073,361
Other Professional Services	$ 34,434,350	$ 66,053,356	$ 16,637,368	$ 102,270,755	$ 15,872,540	$ 7,936,270	$ 227,332,099
Home Health Care	$ 57,970,935	$ 61,810,456	$ 111,012,353	$ 11,259,474	$ 1,747,483	$ 1,310,613	$ 243,363,830
Drugs & Other Medical Non-Durables	$ 87,174,548	$ 55,306,164	$ 71,941,979	$ 223,854,000	$ 34,742,400	$ 34,742,400	$ 473,019,091
Vision Prod & Other Med Durables	$ 61,299,376	$ 7,504,189	$ 15,741,932	$ 35,099,270	$ 5,447,447	$ 4,085,585	$ 123,730,352
Nursing Home Care	$ 95,947,810	$ 129,894,304	$ 292,722,168	$ 1,909,941	$ 296,425	$ 222,319	$ 520,696,543
Other Personal Health Care	$ 24,392,051	$ 100,639,418	$ 51,175,129	$ 131,815,035	$ 20,457,846	$ 10,228,923	$ 318,250,557
Sub Total	$ 978,281,549	$ 753,343,346	$ 752,842,973	$ 1,743,882,558	$ 270,652,592	$ 107,106,961	$ 4,335,457,386
Insurance Payer Administration	$ 21,247,130	$ 51,428,821	$ 40,592,255	$ 257,073,870	$ -	$ -	$ 370,342,075
Total	$ 999,528,678	$ 804,772,167	$ 793,435,227	$ 2,000,956,428	$ 270,652,592	$ 107,106,961	$ 4,705,799,462
						-Pct of ME GDP	13.9%
						-Pct of US GDP	12.3%

NOTE: For Uninsured, two amounts are reported. "Subtotal" represents the estimated personal health expenditures for this population. The "Adjusted" amounts are the estimated, out of pocket payments made by this population. The difference between these two amounts are the estimated charity and bad debt, implicitly included in the expenditures of other population groups (particularly the Privately Insured), is $163,545,631. In order to avoid double counting, The Total for the entire population includes the Adjusted amount for the Uninsured.

Technical Notes for Table 1

1.1 Total population for Maine provided by State Planning Office, Richard Sherwood, July 25, 2000, including estimated undercounts. Medicare population based on 1999 AARP report, *Reforming the Health Care System* and reduced for number of dual eligible persons. Medicaid only and dual population based on 1999 client-count reported by Muskie School, August 30, 2000. Privately insured population based on 1998 EBRI study reporting that 68.8 percent of non-elderly persons in Maine had employment-based coverage (website, EBRI).

1.2 Personal health expenditures for persons principally covered by Medicare are based on 1997 Medicare claims data for Maine as reported by the Muskie School, August 30, 2000. The data were trended to 1998 based on national trend rates by service category (HCFA website, June 2, 2000). No increases were projected for 1999, based on preliminary and aggregate reports as to the impact of the Balanced Budget Act. The claims estimates were increased for out-of-pocket expenses based on data in the March 2000 MEDPAC Report to the Con-

gress: Medicare Payment Policy , "Out of pocket spending on health care by category for all beneficiaries, 1992-1996, adjusted for inflation" (page 41). These data were trended to 1999 and inflated. Resulting amounts were allocated to the reported service categories based on a consensus of the Data Advisory Group. These national estimates were adjusted to Maine based on ratio of per capita Maine personal health expenditures (EBRI Health Benefits Databook, 1st Edition, Wash. D.C. 1999, pg. 21) for 1993 (by service category) to the US (HCFA website, July 11, 2000). Per capita amounts were multiplied by the Medicare population in Maine to determine total expenditures. HCFA estimates administrative expenses to be 3.2 percent of claims (HCFA/ OACT, August 1998).

1.3 Medicaid Paid Amounts and Patient Liability for calendar year 1999 provided by the Muskie School, August 30, 2000 in specified service categories. Drug expenditures reduced 2.1 percent for rebate, based on rebate history for state fiscal year 1998 and 1999 (State Medicaid Report). Third-party liability costs were not removed, since they are legitimate expenditures of this population. Combined state and federal administrative costs for the Medicaid program is estimated to be 6.5 percent of claims (personal communication, HCFA, 8/00). That amount is reduced slightly by including out-of-pocket expenditures in the denominator to calculate the percentage of total personal health expenditures.

1.4 Medicare, Medicaid and out of pocket personal health expenditures for dual eligible beneficiaries were calculated as described above in notes 1.2 and 1.3 except that out of pocket expenditures related to Medicare coverage was not included. Only patient liability expenses associated with the Medicaid program were included.

1.5 Except for that about drugs and other medical non-durable services, private insurance data are grounded in claims information provided by the Maine Health Information Center for the twelve-month period ending September 1999, and for a population of 136,211 employees and dependents associated with the Maine Health Management Coalition (private communication, June 12, 2000). Those data were trended 1.5 percent to a full calendar year. Because Coalition members represent principally large employers in Maine, an adjustment was needed for small employers. The 1997 Medical Expenditure Panel Survey (MEPS website) reported that 45 percent of Maine employees receiving insurance were employed in firms of less than 50 employees. Based on discussions with Bureau of Insurance, it was estimated that health insurance costs for small groups are 25 percent greater (R. Diamond, personal communication, August 11, 2000). Based on these data, a weighed average was calculated for large and small employers. This amount was reduced by 25 percent, representing average employee share of premium expenses in 1998 (EBRI Databook, ibid.) and grossed up 63 percent reflecting the amount of total health expenditures covered by private insurance in 1998 (EBRI Databook, ibid.) Completion factors for personal health expenditures outside of those covered by insurance were based on a consensus of the Data Advisory Group. Finally, personal health expenditures for **Drugs and Other Medical Non-Durable Services** were based on a separate analysis (G. Nalli, personal communication, May 2000).

1.6 **Insurance Payer Administration** was estimated based on filings made with the Maine Bureau of Insurance by major HMO and indemnity carriers providing insurance coverage for 370,000 persons, for the calendar year ending 12/31/99 (G. Griswold, 6/14/00). Given very significant administrative levels in 1999—related in part to reorganization by some companies—an average of 1998 and 1999 levels was used.

1.7 It is estimated that personal health expenditures for **Uninsured** approximate 70 percent of the expenditures for **Private Insurance** (Long, S.H. and Marquis, M.S. "The Uninsured Access Gap and the Cost of Universal Coverage", Datawatch, Health Affairs, Spring 1994, pp. 211-220). That factor was consistently applied across all service categories. Resultant amounts were reduced for bad debt and charity. Personal health expenditures for **Hospital Care** were reduced $105 million based on 1999 estimates provided by Maine Hospital Association (T. Butts, personal communication, June 19, 2000). Except for **Drugs and Other Medical Non-Durable Services,** reductions in the order of 25 percent to 50 percent were applied to all other services based on

anecdotal information and personal communications. No bad debt and charity reductions were taken for **Drugs and Other Medical Non-Durable Services**. Based on those approximations, the total reduction in estimated personal health expenditures for the uninsured population was 60 percent, an amount noted in the literature (Young, R.A., "Third part funding of health care services for the uninsured of Tarrant County", Texas Medicine, 95:8, pp. 50-54).

1.8 In October 2000, HCFA release an update to its estimates of personal health expenditures, by state. Comparing comparable categories of expenditures and trending 1998 data to 1999, estimates in this study vary by 7.9 percent with the HCFA estimates. Assuming a mid point in these estimates and a factor of approximately 5.65 percent as the difference between total personal health expenditures and those expenditures represented by the identified insurance programs in this study, an amount of $270 million is estimated as expenditures related to other payment activities, such as veterans administration, Indian health service, public health clinics and the like.

1.9 Gross domestic product for US calculated based on data reported at HCFA website, June 6, 2000. Gross domestic product for Maine provided by Maine State Planning Office (G. Rose, personal communication, August 1, 2000).

Table 2
Estimated 1999 Health Personal Health Expenditures in Maine as Compared to US

	Medicare		Medicaid		Dual Eligible		Private Insurance		Uninsured				Total			
	Annual Per Person	% Distrib	Annual Per Person	% Distrib	Annual Per Person	% Distrib	Annual Per Person	% Distrib	Subtotal Ann'l/Per	Subtotal Pct	Adjusted Ann'l/Per	Adjusted Pct	Annual Per Person Maine	Annual Per Person US	% Distribution Maine	% Distribution US
Hospital Care	$ 2,469	42.8%	$ 2,156	37.1%	$ 3,983	18.9%	$ 994	37.1%	$ 696	42.5%	$ 61	9.4%	$ 1,291	$ 1,417	34.6%	37.3%
Physician Services	$ 1,091	18.9%	$ 243	4.2%	$ 1,157	5.5%	$ 665	24.8%	$ 466	28.5%	$ 233	36.0%	$ 635	$ 853	17.0%	22.5%
Other Professional Services	$ 199	3.4%	$ 477	8.2%	$ 442	2.1%	$ 137	5.1%	$ 96	5.9%	$ 48	7.4%	$ 180	$ 255	4.8%	6.7%
Home Health Care	$ 334	5.8%	$ 447	7.7%	$ 2,947	14.0%	$ 15	0.6%	$ 11	0.6%	$ 8	1.2%	$ 193	$ 119	5.2%	3.1%
Drugs & Other Med. Non-Dur	$ 503	8.7%	$ 400	6.9%	$ 1,910	9.1%	$ 300	11.2%	$ 210	12.8%	$ 210	32.4%	$ 375	$ 468	10.1%	12.3%
Vision Prod & Other Med Dur	$ 354	6.1%	$ 54	0.9%	$ 418	2.0%	$ 47	1.8%	$ 33	2.0%	$ 25	3.8%	$ 98	$ 51	2.6%	1.3%
Nursing Home Care	$ 554	9.6%	$ 938	16.1%	$ 7,771	36.9%	$ 3	0.1%	$ 2	0.1%	$ 1	0.2%	$ 413	$ 318	11.1%	8.4%
Other Personal Health Care	$ 141	2.4%	$ 727	12.5%	$ 1,359	6.4%	$ 177	6.6%	$ 124	7.6%	$ 62	9.6%	$ 252	$ 127	6.8%	3.3%
Sub Total	$ 5,644	97.9%	$ 5,442	93.6%	$ 19,987	94.9%	$ 2,337	87.2%	$ 1,636	100%	$ 647	100%	$ 3,438	$ 3,608	92.1%	95.0%
Insurance Payer Admin.	$ 123	2.1%	$ 372	6.4%	$ 1,078	5.1%	$ 345	12.8%	$ -	0.0%	$ -	0.0%	$ 294	$ 190	7.9%	5.0%
Total	$ 5,767	100%	$ 5,814	100%	$ 21,064	100%	$ 2,682	100%	$ 1,636	100%	$ 647	100%	$ 3,732	$ 3,798	100%	100%

NOTE: For Uninsured, two amounts are reported. "Subtotal" represents the estimated personal health expenditures for this population. The "Adjusted" amounts are the estimated, out of pocket payments made by this population. The difference between these two amounts are the estimated charity and bad debt, implicitly included in the expenditures of other population groups (particularly the Privately Insured) On a per capita basis, this amount is estimated to be $989.
In order to avoid double counting, the Total for the entire population includes the Adjusted amount for the Uninsured.

Technical Notes for Table 2

2.1 Except for Medicare, annual per-capita expenditures were calculated by dividing personal health expenditures for each service category by the population. Per-capita U.S. expenditures were based on HCFA data (website, July 11, 2000)

2.2 Aggregate **Insurance Payer Administration** for the U.S is based on EBRI data (Health Benefits Databook, 1999, Table 1-2).

Table 3
Estimated 1999 Out of Pocket Expenditures for Health Care in Maine

	Medicare		Medicaid		Dual Eligible		Private Insurance		Uninsured		Total i/o uninsured	
	Annual Per Person	% Out of Pocket	Annual Per Person	% Out of Pocket	Annual Per Person	% Out of Pocket	Annual Per Person	% Out of Pocket	Annual Per Person	% Out of Pocket	Annual Per Person	% Out of Pocket
Hospital Care	$ 2,469	10.9%	$ 2,156	0.0%	$ 3,983	0.0%	$ 994	30.8%	$ 61	n/a	$ 1,477	17.0%
Physician Services	$ 1,091	29.3%	$ 243	0.0%	$ 1,157	0.0%	$ 665	39.6%	$ 233	n/a	$ 696	33.0%
Other Professional Services	$ 199	69.5%	$ 477	0.0%	$ 442	0.0%	$ 137	43.2%	$ 48	n/a	$ 200	31.1%
Home Health Care	$ 334	5.4%	$ 447	0.0%	$ 2,947	0.0%	$ 15	30.0%	$ 8	n/a	$ 221	2.7%
Drugs & Other Med. Non-Dur	$ 503	98.7%	$ 400	0.0%	$ 1,910	0.0%	$ 300	40.0%	$ 210	n/a	$ 400	40.1%
Vision Prod & Other Med Dur	$ 354	45.0%	$ 54	0.0%	$ 418	0.0%	$ 47	49.2%	$ 25	n/a	$ 109	37.5%
Nursing Home Care	$ 554	58.2%	$ 938	3.7%	$ 7,771	12.3%	$ 3	29.3%	$ 1	n/a	$ 475	18.6%
Other Personal Health Care	$ 141	64.0%	$ 727	0.0%	$ 1,359	0.0%	$ 177	56.4%	$ 62	n/a	$ 281	29.2%
Sub Total	$ 5,644	32.1%	$ 5,442	0.6%	$ 19,987	4.8%	$ 2,337	37.5%	$ 647	n/a	$ 3,859	23.9%
Insurance Payer Admin.	$ 123	32.1%	$ 372	0.0%	$ 1,078	0.0%	$ 345	37.5%	$ -		$ 338	27.9%
Total	$ 5,767	32.1%	$ 5,814	0.6%	$ 21,064	4.5%	$ 2,682	37.5%	$ 647	n/a	$ 4,197	24.2%

NOTE: Total amounts for Uninsured are estimated to be: $ 1,636 Charity and bad debt, implicitly included in the expenditures of other population groups (and particularly the Privately Insured), are estimated to be $989.

Total column does not include Uninsured expenditures or population count.

Technical Notes for Table 3

3.1 Adjustments to principal insurance payments discussed above explicitly determined out-of-pocket expenditures. Those amounts are reported as percentages of the total personal health expenditures for each population group and service category, except **Uninsured**. Because 100 percent of estimated expenditures are paid by an uninsured individual, there is no differentiation in out-of-pocket expenditures. As suggested in the footnote, approximately 60 percent of the total expenditures for that population are offset by charity and bad debt considerations.

Table 4
Maine Compared to Identified Benchmark States for 1999

	North Dakota		Wyoming		West Virginia		Vermont		Maine	
	Annual Per Person	Percent Distrib	Annual Per Person	Percent Distrib	Annual Per Person	Percent Distrib	Annual Per Person	Percent Distrib	Annual Per Person	Percent Distrib
Hospital Care	$ 1,480	40.9%	$ 1,291	41.7%	$ 1,623	43.2%	$ 1,208	35.8%	$ 1,347	38.1%
Physician Services	$ 790	21.8%	$ 563	18.2%	$ 702	18.7%	$ 616	18.2%	$ 630	17.8%
Other Professional Services	$ 219	6.0%	$ 246	8.0%	$ 272	7.2%	$ 308	9.1%	$ 265	7.5%
Home Health Care	$ 34	0.9%	$ 88	2.8%	$ 122	3.2%	$ 128	3.8%	$ 117	3.3%
Drugs & Other Med. Non-Dur	$ 414	11.4%	$ 397	12.8%	$ 521	13.9%	$ 462	13.7%	$ 440	12.4%
Vision Prod & Other Med Dur	$ 49	1.3%	$ 48	1.6%	$ 51	1.4%	$ 50	1.5%	$ 45	1.3%
Nursing Home Care	$ 477	13.2%	$ 238	7.7%	$ 267	7.1%	$ 336	9.9%	$ 460	13.0%
Other Personal Health Care	$ 155	4.3%	$ 222	7.2%	$ 200	5.3%	$ 271	8.0%	$ 233	6.6%
Sub Total	$ 3,617	100.0%	$ 3,093	100.0%	$ 3,758	100.0%	$ 3,380	100.0%	$ 3,537	100.0%

NOTE: Amounts for Maine vary modestly from earlier amounts, reflecting different methodology used to make State comparisons. While previous estimates are considered more accurate, state comparisons are better made utilizing similar methodology.

Technical Notes for Table 4

4.1 Based on demographic and income characteristics, the State Planning Office ranked the forty nine states as to their similarity to Maine, based on demographic and income characteristics (R. Sherwood to C. Freshley, personal communication, July 13, 2000). The three most similar states were North Dakota, Wyoming and West Virginia. Because there was interest in comparing another New England state to Maine, Vermont was also included. Vermont ranks seventh to Maine based on this index.

4.2 Personal health expenditures by state were reported in a 1993 HCFA analysis. Per capita expenditures were calculated with 1993 population data provided by the US Census (website, July 22, 2000). Based on national trends, these data were inflated on a service specific basis to 1999. Adjustments for inter-state expenditures were provided by HCFA and made on a service-specific basis (personal communication, August 2000). Based on 1999 populations, total personal health expenditures were calculated for each state.

Table 5
Change in Estimated Personal Health Expenditures in Maine
(without Insurance Administration) for Select Years

	1994		1999			2004			2009		
	Per Capita	Total (000)	% Chg-PC	Per Capita	Total (000)	% Chg-PC	Per Capita	Total (000)	% Chg-PC	Per Capita	Total (000)
Hospital Care	$ 1,130	$1,407,518	14.3%	$ 1,291	$ 1,627,992	27.1%	$ 1,641	$ 2,111,190	21.8%	$ 1,998	$2,642,845
Physician Services	$ 531	$ 661,444	19.6%	$ 635	$ 801,073	30.7%	$ 830	$ 1,068,389	24.5%	$ 1,034	$1,367,369
Other Professional Services	$ 131	$ 163,800	37.1%	$ 180	$ 227,332	36.9%	$ 247	$ 317,451	27.0%	$ 313	$ 414,418
Home Health Care	$ 154	$ 191,917	25.3%	$ 193	$ 243,364	35.3%	$ 261	$ 335,943	36.0%	$ 355	$ 469,855
Drugs & Other Med. Non-Dur	$ 236	$ 293,535	59.2%	$ 375	$ 473,019	50.0%	$ 563	$ 723,938	38.5%	$ 779	$1,030,696
Vision Prod & Other Med Dur	$ 88	$ 110,241	10.9%	$ 98	$ 123,730	23.5%	$ 121	$ 155,947	19.5%	$ 145	$ 191,649
Nursing Home Care	$ 341	$ 425,234	21.0%	$ 413	$ 520,697	25.5%	$ 518	$ 666,594	25.2%	$ 649	$ 858,196
Other Personal Health Care	$ 161	$ 200,507	56.8%	$ 252	$ 318,251	62.2%	$ 409	$ 526,701	61.4%	$ 661	$ 874,183
Sub Total	$ 2,773	$3,454,197	24.0%	$ 3,438	$ 4,335,457	33.5%	$ 4,590	$ 5,906,153	29.3%	$ 5,934	$7,849,210
	Consumer Price Index:		12.3%								

Note: 1999 is the base year for all the above projections, as adjusted by national trends on a service specific basis. For 1994, 1999 estimates were reduced by the per capita percent reported in 1999. 1999 per capita estimates were increased by the 2004 percent to project 2004 expenditures. 2004 per capita estimates were increased by the 2009 percent to project 2009 expenditures.
Note: PC means per capita

Technical Notes for Table 5

5.1 Estimates for 1994, 2004 and 2009 were based on national trends reported by HCFA on a service-specific basis (website, July 11, 2000). The adjustments were applied to the 1999 per capita estimates for Maine. Population estimates were provided by the State Planning Office to calculate total expenditure levels (R. Sherwood, personal communication, July 25, 2000).

5.2 Consumer price index information based on data reported by the Bureau of Labor Statistics for US (website, July 22, 2000).

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